MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09088

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:
County: Howard
City or town: rural - Dayton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: rural - Dayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: - - - -

3.(a) FULL NAME: Annie Hill Brown

3.(b) Social Security Number: - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Oliver L. Brown
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): November 4, 1868

8. AGE: Years: 77 | Months: 10 | Days: 3 | If less than one day: ....hrs. ....min.

9. Birthplace: Clarksville, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: John Hill
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucrecia Thompson
15. Birthplace: Maryland

16. Informant: Oliver L. Brown
Address: RFD 2, Brookeville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1946 (month) (day) (year)
Cemetery or crematory: Linthicum Chapel
Location: Clarksville, Md.

18. Funeral director: F.C. Higinbothom
Address: Ellicott City, Md.

19. Sept 8 1946 (Date rec'd by registrar) Marie C. Whitaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1946 at 3:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to Sept. 7 1946 and that I last saw her alive on September 7 1946

Immediate cause of death	DURATION
Acute cardiac decompensation	12 hrs.
Due to: Myocardial insufficiency	7 days
Due to: Arteriosclerosis	5 years
Other conditions: Acute bronchitis	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles S. Whitaker M.D.
M. D. or other
Address: Clarksville, Md. Date signed: 9/8/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-L

CERTIFICATE OF DEATH

09089

Reg. Dist. No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Howard

City or town: Ilchester, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ilchester
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lena Chaffman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Chaffman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 14, 1858.

8. AGE:

Years	Months	Days	If less than one day
88	5	28	hrs. min.

9. Birthplace: Baltimore County Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Peter Parks
13. Birthplace: Unknown

MOTHER
14. Maiden name: Susan ?
15. Birthplace: Unknown

16. Informant: Dr. Leon Kochman
Address: Ellicott City, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 14, 1946 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Ilchester, Maryland.

18. Funeral director: Easton Sons
Address: Ellicott City, Maryland.

19. Sept. 13, 1946 (Date rec'd by registrar) John B. Lucas Per. B. E. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 1946, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1940 to Sept 11 1946
and that I last saw h[illegible] alive on Sept 11 1946

Immediate cause of death	DURATION
Generalized atherosclerosis	7
cardiovascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Emil Kochman M.D. M. D. or other

Address: Ellicott City Md Date signed: 9/13/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (146)

Registered No. 191

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland HOWARD CO.
(b) Street address West Friendship, Maryland.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County HOWARD ~~West Friendship~~
(c) City or town West Friendship
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Conkens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years 15 | Months ? | Days ? | If less than one day ____ hr. ____ min.

9. Birthplace Harlan Ky.
(Town, county, and state)

10. Usual Occupation Saw mill

11. Industry or business

FATHER
12. Name David Conkens.
13. Birthplace Ky.

MOTHER
14. Maiden Name Lula Kellem
15. Birthplace Ky.

16 (a) Informant Earl Blanton
(b) Address West Friendship Md

17 (a) Removal for Burial (Burial, cremation, or removal) (b) Date thereof 9-10-46 (month) (day) (year)
(c) Cemetery or crematory Fogwell
Location Fogwell Iowa

18 (a) Funeral director D.C. Heginbotham
(b) Address Ellicott City Md

19 (a) Sept. 10, 1946 (Date rec'd by registrar) (b) John B. Laughman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 4.10 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of chest involving heart and lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-46 at 1.45 P. M.
(b) Where did injury occur? West Friendship, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm

23. Signature Howard J. Mencin M.D.
Medical Examiner.
Date signed 9-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09091

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Howard

City or town Elkridge Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Montgomery Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Thomas Fields

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widow

6.(b) Name of husband or wife Emma Fields

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1885

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace Prince George Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Robert Fields

13. Birthplace Va.

MOTHER 14. Maiden name Martha Brewer

15. Birthplace Md.

16. Informant Robert Fields

Address Montgomery Rd.

17. Burial (Burial, cremation, or removal) (which?) Date thereof Sept. 13, 1946 (month) (day) (year)

Cemetery or crematory Laurel Cem.

Location Elkridge Md.

18. Funeral director Mrs. Katie A. Williams

Address 3229 W. Lombard St.

19. 9/13/46 19 (Date rec'd by registrar) A. W. Dedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 46 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 19 46 to Sept 9 19 46 and that I last saw h alive on 19

Immediate cause of death	DURATION
Hypertensive Cardiac Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. Woolridge M. D. or other

Address Elkridge Md. Date signed 9-12-46

17

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

★ 09092

Reg. Diat. No. 190

1. PLACE OF DEATH:
County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5726 Old Wash Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas L. Gill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jane V. (Mrs.) Gloskay
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): May 19th 1863

8. AGE: Years: 83. Months: 3 Days: 29. If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkridge, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Contractor
FATHER 12. Name: Laurence Gill
13. Birthplace: Ireland
MOTHER 14. Maiden name: Estelle Hogan
15. Birthplace: Edgeall, Calvert Md.
16. Informant: Mrs. Jane V. Gill
Address: 5726 Old Wash Blvd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/46. (month) (day) (year)
Cemetery or crematory: St. Augustines Cem.
Location: Elkridge, Md.
18. Funeral director: Talbert Conrad & Son
Address: 3063 Baltimore Blvd.
19. Sept. 19 1946 (Mrs.) Bird Williams Registrar
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17th 1946 at 4:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Sept 17 1946
and that I last saw h[illegible] alive on Sept 13 1946

Immediate cause of death	DURATION
Carcinoma of Caecum & Colon	6 mo
Due to: Myocarditis & Decompensation	2 mo
Due to: Senile Senility	1 mo
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Main St Elkridge Date signed: 9/18/46

VS A15 5-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

09093

CERTIFICATE OF DEATH

Reg. Diat. No. 195

1. PLACE OF DEATH:
County Howard
City or town Gilford Road, Ellicott City, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Many years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicott City - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Gilford Road, R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Griffin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1, 1879.

8. AGE: Years 67 | Months 3 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace Howard Co. Maryland. (Town, county, and state)

10. Usual occupation Farm Work

11. Industry or business —

FATHER
12. Name Thomas Griffin
13. Birthplace Virg.

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant John Wells
Address Ellicott City, R.F.D. Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 9/17/46. (month) (day) (year)
Cemetery or crematory Trinity Cemetery - Chapel
Location Pfeffers Corners, Howard Co. Md.

18. Funeral director Easton Sons
Address Ellicott City, Maryland.

19. 9/17/46 19 (Date rec'd by registrar) Frank S. Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1946, at 6.45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4th, 1946, to Sept. 14, 1946
and that I last saw h... alive on Sept. 14th, 1946

Immediate cause of death		DURATION
Sept. 10th, 1946	Cerebral Embolism	10 wks.
Due to	—	
Due to	—	
Other conditions	Paralysis L left arm.	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank S. Shipley, M.D.
M. D. or other
Address Savage, Md. Date signed 9/17/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

09694

Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Howard

City or town: Savage (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? transient.

Hospital, institution, or street address where death occurred: Balto-Wash. Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Philadelphia

City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1558 N. 11th St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mitchell E. Lanier Jr.

3.(b) Social Security Number: 165-07-8643

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife: Almetter Lanier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 23, 1909

8. AGE:

Years	Months	Days	If less than one day
37	4	22	..... hrs. ..... min.

9. Birthplace: Statesboro, Ga.
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER — 12. Name: Algie Lanier

13. Birthplace: Georgia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Georgia

18. Informant: Almetta Lanier

Address: 1558 N. 11th St Philadelphia Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-46 (month) (day) (year)

Cemetery or crematory: Mt Lawn

Location: Delaware County Penna

18. Funeral director: J.C. Hyndman & Son

Address: Elkton City Md

19. 9-16 19 46 (Date rec'd by registrar) Frank R. Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/15 19 46, at 4 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/15 19 46, to 9/15 19 46

and that I last saw h[illegible] alive on no date 19

Immediate cause of death	DURATION
Fracture of Skull at base	instant
Due to	
Due to	
Other conditions: multiple fractures and abrasions (Include pregnancy within 3 months of death)	instant

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/15/46

Where did injury occur? Near Savage (City or town) Howard (County) Md (State)

Injured at home, farm, industry, public place (where?) Balto.-Washington Blvd.

Means of injury: Struck by auto Injured at work? no

23. SIGNATURE: George E. Buegler M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address: Elkton Md Date signed 9/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

09095

P

CERTIFICATE OF DEATH

Reg. Diat. No. 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Manta Domay Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John R Rhubottom

3.(b) Social Security Number 214-01-6430

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single.

8.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1893

8. AGE:

Years	Months	Days	If less than one day
53	8	10	..... hrs. ..... min.

9. Birthplace Elkridge Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Geo Rhubottom
13. Birthplace Md

MOTHER
14. Maiden name Sophia Brown
15. Birthplace Md

16. Informant Mrs. Luverna Conyer
Address 1732 McCullough St. Balto 17, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-46 (month) (day) (year)
Cemetery or crematory St Stephens
Location Elkridge Md

18. Funeral director J. C. Rhubottom
Address Ellicott City Md.

19. 9/19 1946 Mrs Hedrick DM
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1946, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/17 1946, to 9/17 1946
and that I last saw him alive on no date 19

Immediate cause of death	DURATION
Coronary Thrombosis	15 minutes
Due to Arteriosclerotic Vascular disease	1 year
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George E. Burtnett M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Ellicott City, Md. Date signed 9/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

69096

★ Reg. Dist. No. 195

1. PLACE OF DEATH:
County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs.
Hospital, institution, or street address where death occurred: 1776
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Balto. City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 940 Woodale St.
(If rural, give LOCATION)
2.(a) If veteran, name war: n.d.

3.(a) FULL NAME: Carl P. Schaller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 15 1900

8. AGE: Years 46.45! Months 5 Days 8 If less than one day: hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Salesman - Wand Bak
11. Industry or business:

FATHER
12. Name: Charles C Schaller
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine [illegible] Fredrick
15. Birthplace: Baltimore Md

16. Informant: Ernest F. Schaller
Address: 423 S. Lehigh St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9.26.1946 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: North ave. Ext.
18. Funeral director: Kendall - Dippel
Address: 312 S. Highland ave
19. 9/23/46 (Date rec'd by registrar) 19 Frank Shipley, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23rd 1946 at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23rd 1946 to Sept 23rd 1946 and that I last saw h[illegible] alive on Sept. 23rd 1946

Immediate cause of death	Coronary Thrombosis	DURATION 2 hrs.
Due to	✓	
Due to	✓	
Other conditions	✓	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D.
Address: Savage, Md. M. D. or other
Date signed: 9/23/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

09097 P

Reg. Dist. No. 190

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Victor Steininger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mary Minnie Steininger
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1867

8. AGE:

Years	Months	Days	If less than one day
78	11	27	— hrs. — min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: Minister
FATHER 12. Name: Joseph Steininger
FATHER 13. Birthplace: Pennsylvania.
MOTHER 14. Maiden name: Sarah Knepp.
MOTHER 15. Birthplace: Pennsylvania.
16. Informant: Mrs. Bertha Parkinson
Address: Ellicott City, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-19-46 (month) (day) (year)
Cemetery or crematory: Delapan First Meth. Church
Location: Delapan Md.
18. Funeral director: John C. Miller Inc.
Address: 2435 E. Oliver St.
19. 9-16 1946 (Date rec'd by registrar) Carl Hecker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Sept. 1946, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Sept 1946, to 16 Sept 1946 and that I last saw him alive on 14 Sept. 1946

	DURATION
Immediate cause of death: Uremia	1 week
Due to: Chronic Nephritis	?
Due to: Hypertensive Cardio-Vascular Disease	?
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William H. Sassaman, M.D. or other
Address: Ellicott City, Md. Date signed: 16 Sept, 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

05098

CERTIFICATE OF DEATH

★ Reg. Dist. No. 191

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: College Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Katherine Gertrude Stickelman

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Orr O. Stickelman
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 26, 1888.

8. AGE: Years	Months	Days	If less than one day
58	3	11	... hrs. ... min.

9. Birthplace: Franklintown Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: John J. Mahon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bridget Nee
15. Birthplace: Unknown

16. Informant: Dr. Leon Kochman
Address: Ellicott City, Maryland.

17. Burial (Burial, cremation, or removal. Which) Date thereof: Sept. 9 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: 4300 Old Frederick Rd. Baltimore, Md.

18. Funeral director: Easton Sons
Address: Ellicott City, Maryland.

19. Sept. 7, 1946 (Date rec'd by registrar) John B. Longhaus Pro. R. E. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1946 at 9 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Sept 6 1946
and that I last saw h... alive on Sept 6 1946

Immediate cause of death: Hypertensive Cardiovascular disease — DURATION: ?
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Jean O. Kochman M. D.
M. D. or other
Address: Ellicott City, Md. Date signed 9/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

09099

★ Reg. Diat. No. 195

1. PLACE OF DEATH:
County Howard
City or town Jessup Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, institution, or street address where death occurred:
Guilford Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Jessup Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. Guilford Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Herbert Hollmerhausen Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Elizabeth Hollmerhausen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	10	2	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm

FATHER
12. Name Herbert Hollmerhausen Sr.
13. Birthplace Germany

MOTHER
14. Maiden name Christine Seese
15. Birthplace Baltimore, Maryland

16. Informant Leonard Hollmerhausen
Address Jessup, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 16, 1946 (month) (day) (year)
Cemetery or crematory Pfeffers Corner
Location Pfeffers Corner, Md.
18. Funeral director Elkridge Funeral Home
Address Laurel, Maryland

19. 9/14/46 19..... Frank S. Shipley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13th 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jan. 1st 1945 to Sept 13th 1946
and that I last saw him alive on Sept. 13th 1946.

	DURATION
Immediate cause of death Myocardial insuff. -	1 month
Due to Hypertensive - Cardio-vascular disease	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank S. Shipley M.D. M. D. or other
Address Savage, Md. Date signed 9/14/46

VS A15 9.45-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING